utah department of human services
QUALITY AND DESIGN

Fiscal Year 2019
FATALITY REVIEW SUMMARY

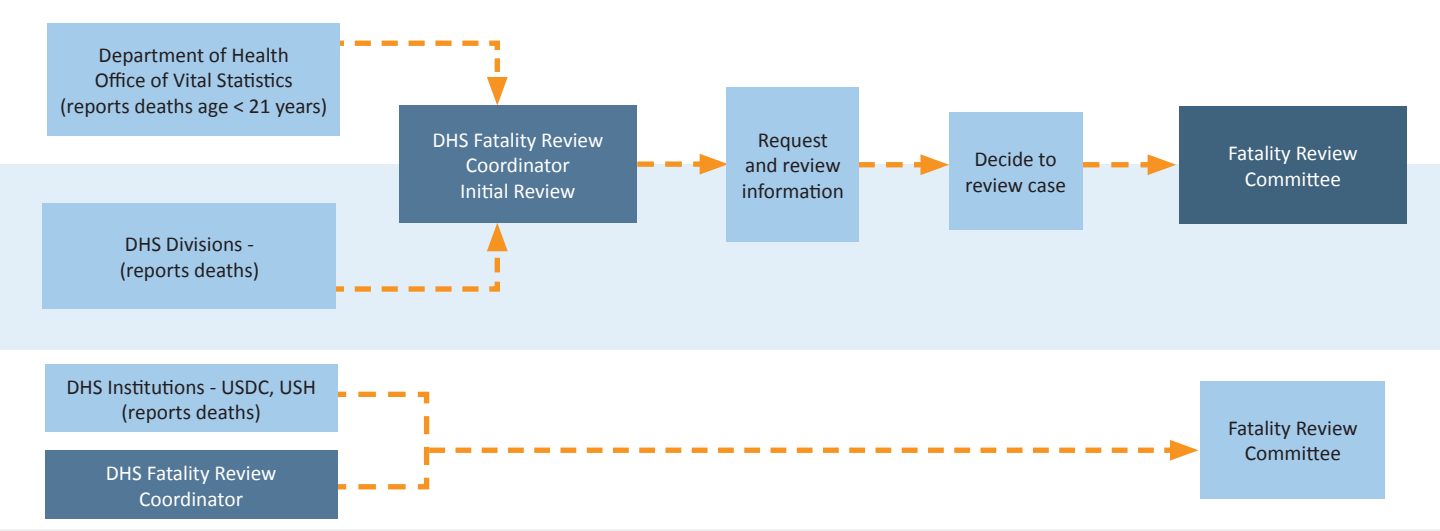
The Department of Human Services (DHS) Fatality Review Committee (Committee) reviews cases of individuals who themselves, or a family member, had an open case with a DHS division at the time of their death or, in some cases, within up to 12 months preceding the death.

Committee members are statutory appointees and professional partners whose expertise adds to the review findings. It includes representatives from the Guardian Ad Litem, law enforcement, medical profession (Safe and Healthy Families), Attorney General's Office, a Children's Justice Center representative, a Suicide Prevention and Crisis Services expert, risk management and DHS division administration. The reviews are managed through a Fatality Review Coordinator in the DHS Office of Quality and Design.

DHS Divisions Included

- Aging and Adult Services (DAAS), Adult Protective Services (APS)
- Child and Family Services (DCFS)
- Juvenile Justice Services (JJS)
- Public Guardian (OPG)
- Services for People with Disabilities (DSPD)
- Utah Developmental Center (USDC)
- Utah State Hospital (USH)

Fatalities are reported and reviewed in the following manner:



The Committee reviews include in-depth information from case logs, law enforcement, the Office of the Medical Examiner (ME) and Vital Statistics. Reviews identify issues in case practice and service delivery on specific cases, provide insight into systemic strengths and highlight areas in which changes or modifications could improve safety and response to client needs. The Committee reports detailed findings to the DHS Executive Director, the legislative Child Welfare Oversight Panel and the legislative Health and Human Services Interim Committee and shares recommendations with leaders of DHS divisions and institutions with case oversight.

While case details are not public record, Utah Code 62A-16-302(5) requires that DHS provide an annual aggregate summary of fatalities of qualifying individuals, which includes:

- the number and type of fatalities
- the number of formal reviews conducted by the Committee
- the gender, age, race and other significant categories of individuals
- the number of deaths by suicide

FY 2019
PROCESS IMPROVEMENTS

During FY19, DHS made several changes to strengthen the fatality review process and systemic recommendations, including:

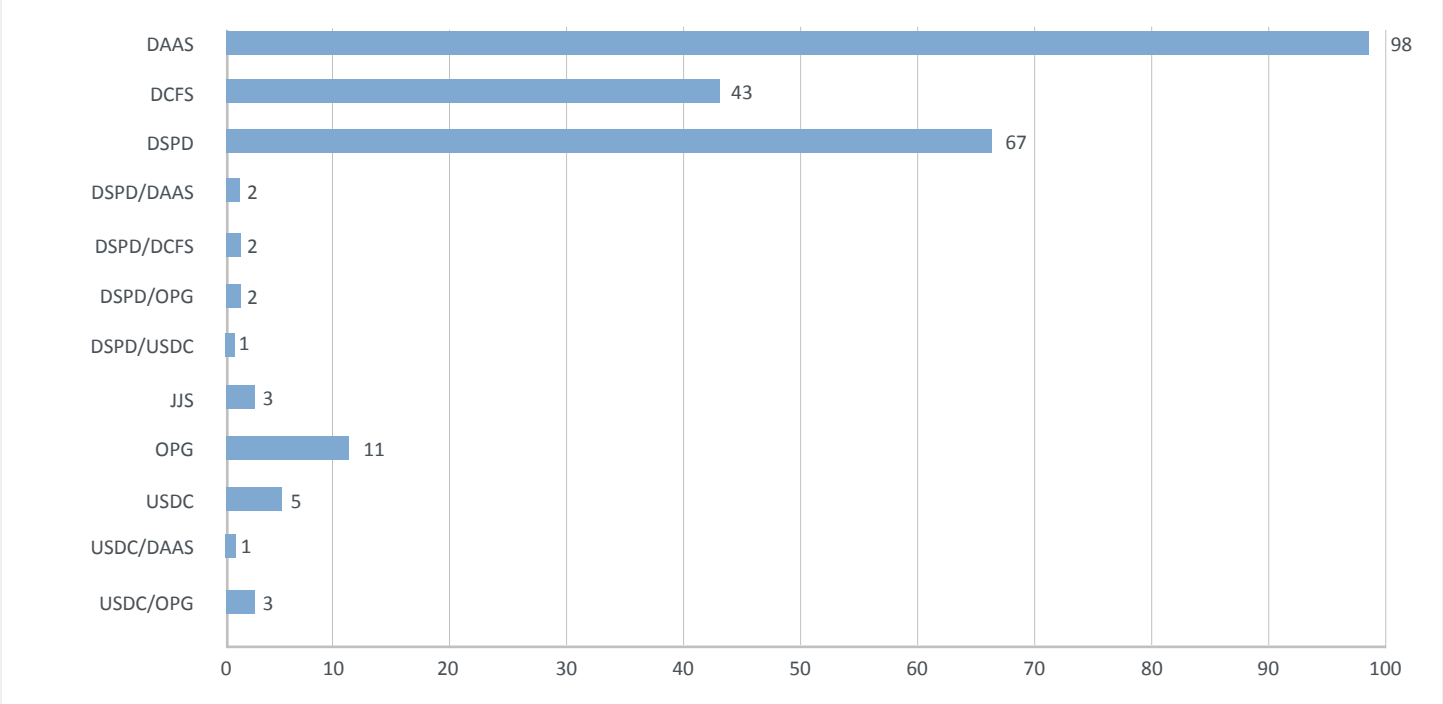
- Added two new Committee members from the Children's Justice Center and Suicide Prevention and Crisis Services
- Began holding Systemic Review meetings to discuss recommendations and trends across cases
- Assembled DHS specialized group of analysts to explain data trends observed by the Committee
- Invited national experts in safety science to make additional improvements to the review process (to be implemented in FY20)
- Changed from bi-monthly to monthly Committees meetings to allow for more time to request information for thoughtful review and to implement system improvements sooner

DATA
& FINDINGS

Important Note:

Data contained in this report reflects fatalities reviewed by the Committee in FY19, however actual deaths may have occurred earlier that were awaiting information for the review.

Reported Deaths by Division, Total Reported Deaths: 238



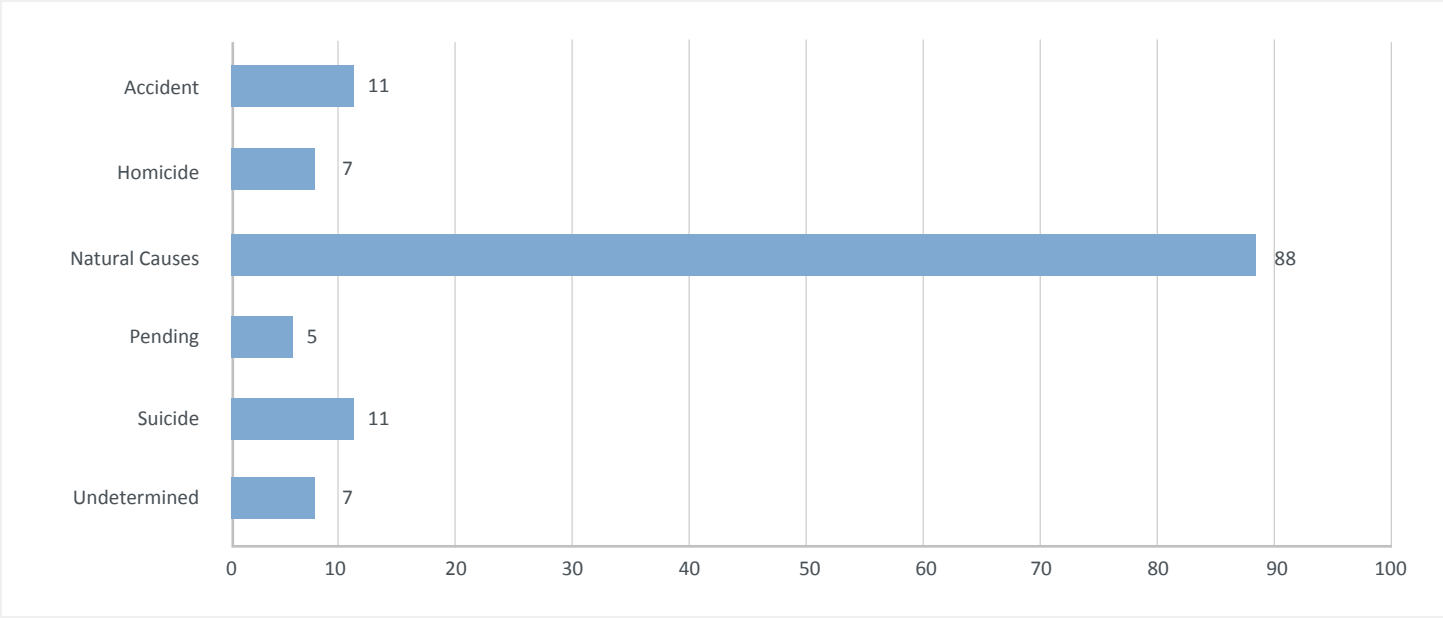
FY 2019

FORMALLY REVIEWED FATALITIES

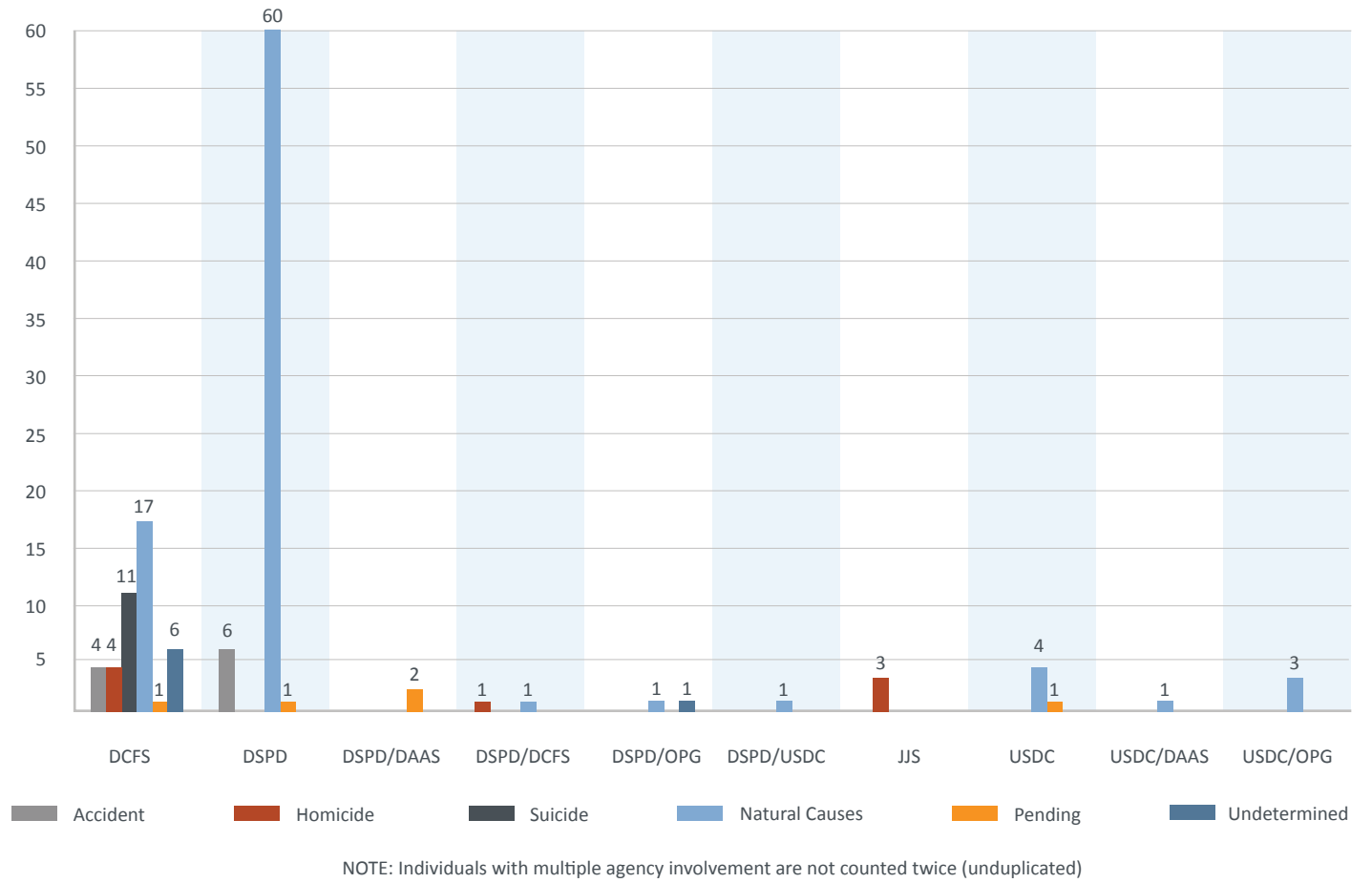
During FY19, there were 129 qualifying individuals in the 238 reported fatalities. The Committee completed 120 fatality reviews of the 129 qualifying individual fatalities. The remaining 9 are in process for Committee review. DHS' Institutions, USDC and USH, conduct fatality review committee reviews on all deaths and include the DHS Fatality Review Coordinator. Because they had a formal review process, these deaths are included with the Committee reviewed data.

- The Committee reviewed all deaths 21 and younger who met the criteria.
- The Committee reviewed all DSPD deaths.
- There were no fatalities that met the criteria for committee review by USH or APS.
- If an individual has multiple division involvement, a committee review applies.
- 11 fatalities were reported for individuals served by more than one agency.
- OPG reported deaths that had more than one agency involved were reviewed.
- JJS had three fatalities reported in FY19 that will be reviewed in FY20 pending more information.

Reviewed Cases, Manner of Death Per Medical Examiner



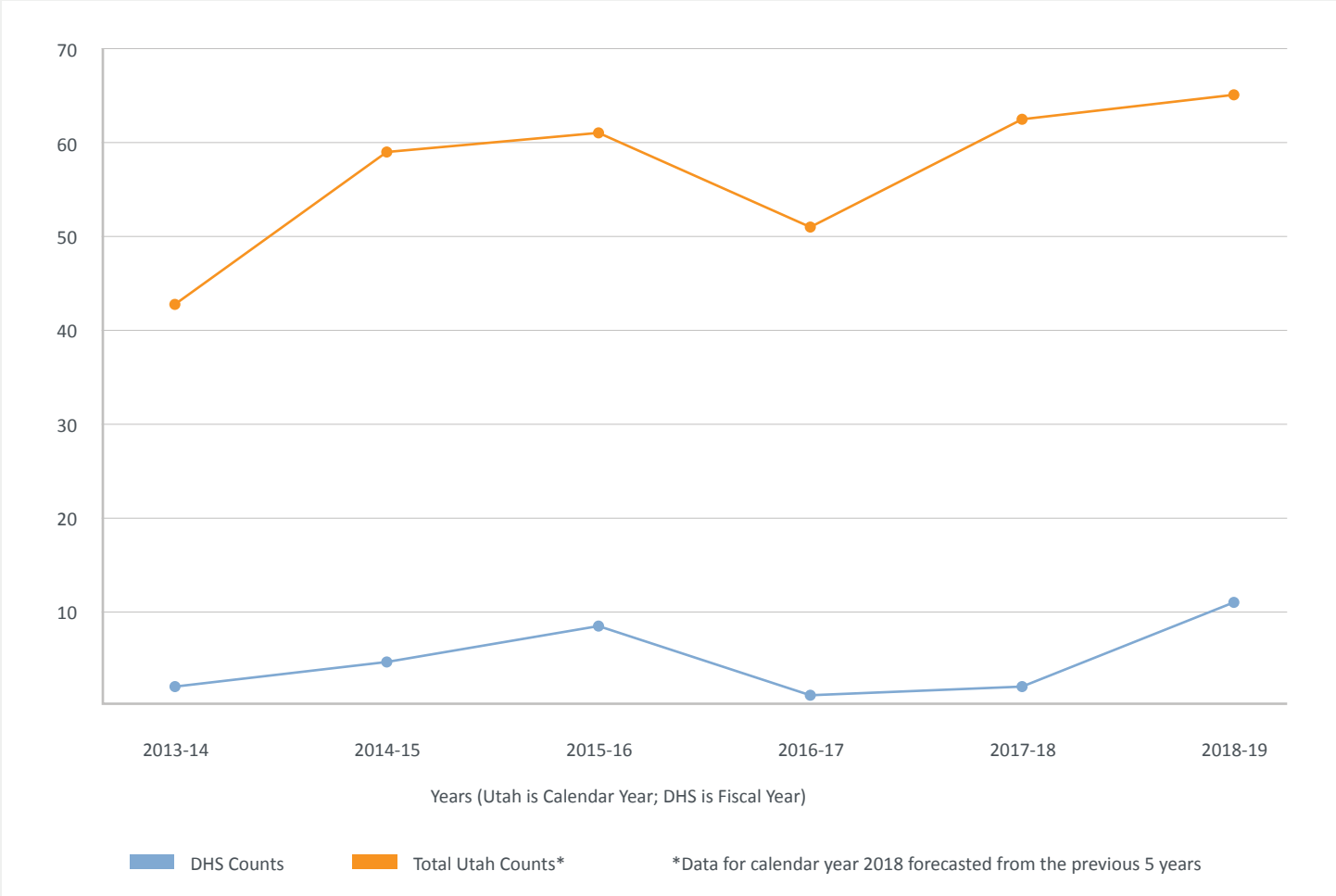
Reviewed Cases, Medical Examiner Manner of Death by Division



NOTE: Individuals with multiple agency involvement are not counted twice (unduplicated)

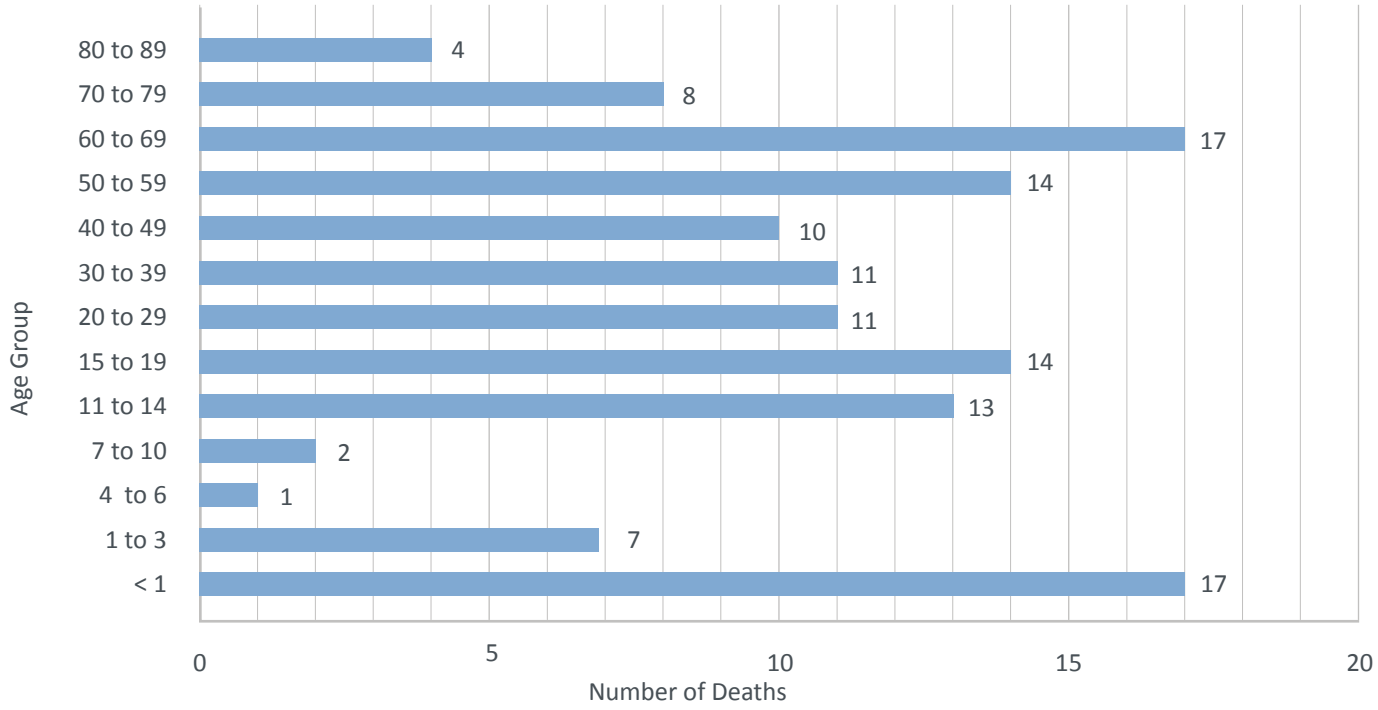
- DSPD reported the highest number of qualifying fatalities. DSPD provides home- and community-based services to individuals with disabilities of all ages, many of whom have complex medical needs. Almost all DSPD fatalities were determined to be due to natural causes, which increased overall this year.
- 10 fatalities were residents of USDC and received a formal review by the institution with representation by the Fatality Review Coordinator. Of these, 9 were determined to be by natural causes and 1 was reviewed while causal information was pending.
- Of the DCFS-involved fatalities:
    - 24 had open cases at the time of the fatality and 21 had previous, but not current open cases.
    - 4 children were reported to have died as a direct result of abuse or neglect by their parents, caretakers or family members.
        - 2 Child Protective Services investigations were opened as a result of the reported abuse, which resulted in the fatality
        - 2 had current DCFS involvement with 1 of the 2 being in a DCFS out-of-home placement.
        - 2 were less than 1 years old, 1 was between 1-3 years old and 1 was between 7-10 years old.
        - These fatalities are of the utmost concern and received thorough reviews and resulted in multiple recommendations as well as a focused initiative on safety assessment within DCFS.

DHS Involved and Statewide Youth Suicide Deaths 11-19 yo

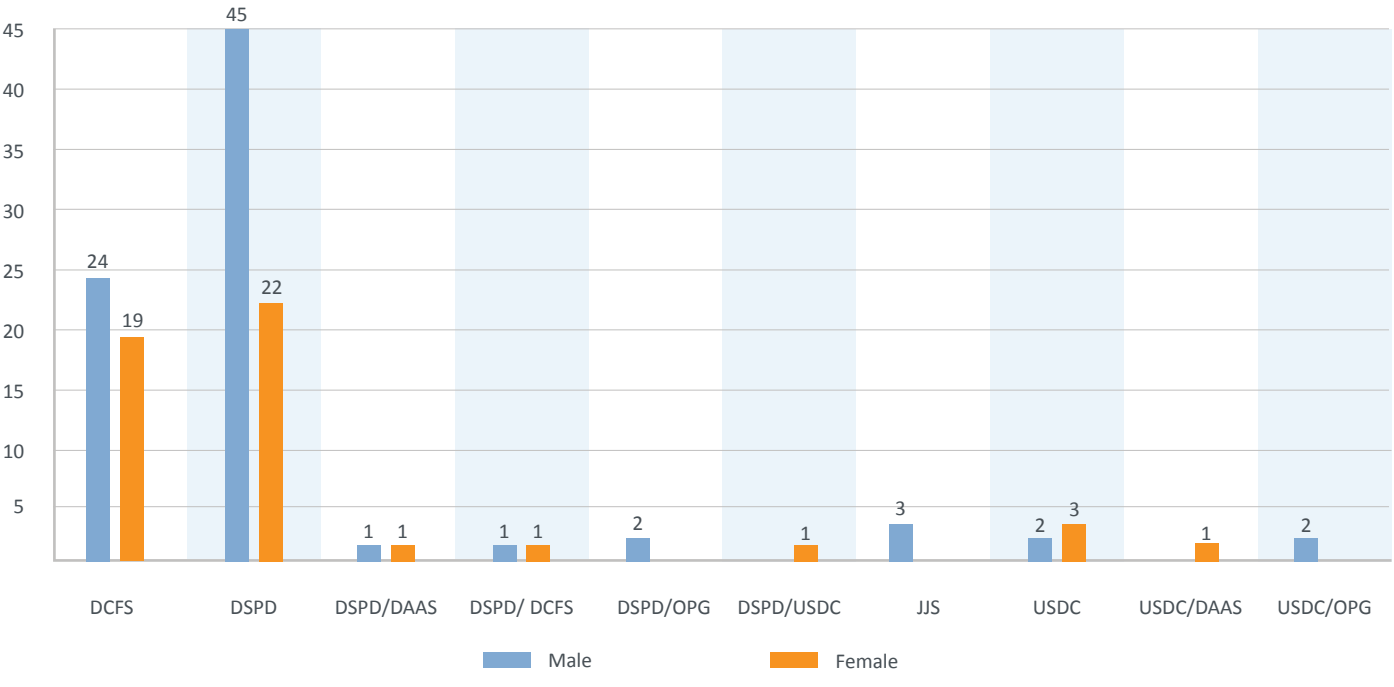


- Child deaths by suicide in FY19 increased from FY18 from 2 to 11. While this follows a similar trend to overall Utah child deaths by suicide, it is a more significant increase.
    - 7 of these suicides were children ages 15-19 and 4 were children ages 11-14.
- The increase in suicides is of significant concern to both the Committee and to DCFS. The Committee gave multiple recommendations related to suicides to DCFS, several of which they were already or now are addressing, including:
    - increasing the circumstances under which DCFS screens children for risk of suicide
    - modifying the training and support for caseworkers in screening for suicide
    - obtaining more information about treatment history when a risk is identified
    - improving caseworker knowledge regarding resources for children who are at risk of suicide
    - working with local experts to implement an evidence-informed process to determine when a screening is needed
    - implementing processes regarding improved safety assessments, prevention and intervention of youth deaths by suicide

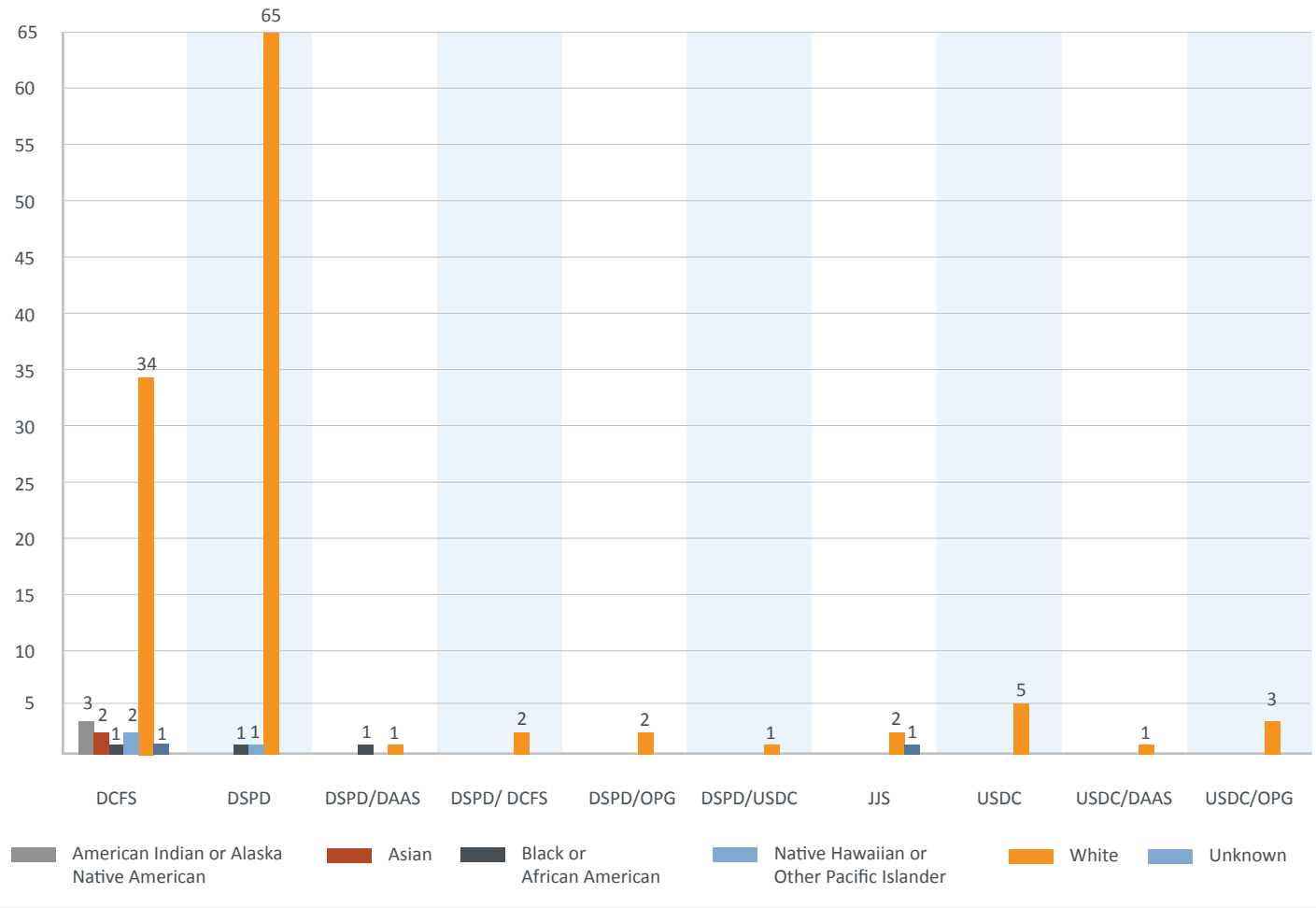
Reviewed Cases by Age Distribution



Reviewed Cases by Gender and Division



Reviewed Cases by Race and Division



RECOMMENDATIONS

Recommendations from individual and systemic reviews included:

- Changes to suicide screening and prevention efforts
- Follow-up investigations by the division
- Clarifying procedures including the burden of proof in conflict investigations
- Improving access to independent medical opinions
- Enhancing safety training for caseworkers
- Addressing caseworker stress, fatigue, workload and turnover
- Increasing the availability of services for children and families and referrals to appropriate services for families

These recommendations were in addition to various specific recommendations on cases. The Committee issued no recommendations regarding changes to state law, but some issues are being tracked for potential changes to statute in the future.

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